Your 2025 Evidence of Coverage

LINET
LIMITED INCOME NET PROGRAM

X0001_EOC_LI NET_PDP_2025_C

OMB Approval 0938-1051 (Expires: August 31,2026)

January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of the Limited Income NET (LI NET) Program

This document gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Care at 1-800-783-1307. (TTY users should call 711). [Hours are 8 a.m. – 7 p.m., Eastern Time Monday – Friday]. This call is free.

This plan, the Limited Income NET (LI NET) Program, is offered by Medicare and is administered by Humana Insurance Company and Humana Insurance Company of New York. (When this Evidence of Coverage says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means LI NET.)

This document is available for free in Spanish. This information is available in a different format, including Braille, large print, and audio. Please call Customer Care at the number listed above if you need plan information in another format.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2026.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

2025 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in LI NET, which is a Medicare Prescription Drug Plan

You are covered by Original Medicare or another health plan for your health care coverage, and you are receiving your Medicare prescription drug coverage through our plan, LI NET.

LI NET is a temporary Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered drugs* refer to the prescription drug coverage available to you as a member of LI NET.

It's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned, or just have a question, please contact Customer Care.

Section 1.3 Legal information about the *Evidence of Coverage*

This Evidence of Coverage is part of our contract with you about how LI NET covers your care. Other parts of this contract include your confirmation of enrollment letter and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for months in which you are enrolled in LI NET between January 1, 2025, and December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve LI NET each year.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B)
- You are eligible for Medicare Part D
- You are not currently enrolled in another Medicare Part D plan
- You are not enrolled in a Medicare Advantage plan that doesn't allow concurrent enrollment in a stand-alone Part D plan
- You are not enrolled in a certain type of employer/union group health plan including Veteran Affairs (VA)
- You have not opted out of Medicare's auto-enrollment process
- You have Medicaid or are otherwise eligible for Medicare's Extra Help or Supplemental Security Income (SSI)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area) Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Section 2.2 Here is the plan service area for LI NET

LI NET is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes all 50 states and the District of Columbia.

If you move, please call Customer Care and update your information.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan, you must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify LI NET if you are not eligible to remain a member on this basis. LI NET must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your confirmation of enrollment letter

While you are a member of our plan, you must use your confirmation of enrollment letter for prescription drugs you get at any pharmacy. You should also show the provider your Medicaid card, if applicable.

Please carry your letter with you at all times and remember to show your letter when you get covered drugs. If your plan membership letter is damaged, lost, or stolen, call Customer Care right away and we will send you a new letter.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

SECTION 4 Your monthly costs for LI NET

Section 4.1 Plan Premium

You do not pay a separate monthly plan premium for LI NET.

SECTION 5 Keeping your plan membership record up to date

Your membership record has information such as your address and telephone number. It shows your specific plan coverage.

Pharmacists need to have correct information about you. **These providers use your membership record to know what drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Customer Care.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 6 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)

- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:
Important phone numbers and resources

SECTION 1 LI NET contacts (how to contact us, including how to reach Customer Care)

How to contact our plan's Customer Care

For assistance with claims, billing, or member card questions, please call or write to LI NET Customer Care. We will be happy to help you.

Method	Customer Care – Contact Information
CALL	1-800-783-1307 Calls to this number are free. You can call us [Monday through Friday 8 a.m. to 7 p.m., Eastern Time.] Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
FAX	1-877-210-5592
WRITE	Limited Income NET Program P.O. Box 14310 Lexington, KY 40512-4310
WEBSITE	Humana.com/LINET

How to contact us when you are asking for a coverage decision or appeal

A coverage decision is a decision we make about your coverage or about the amount we will pay for your Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Part D prescription drugs – Contact Information
CALL	1-800-783-1307 Calls to this number are free. You can call us [Monday through Friday 8 a.m. to 7 p.m., Eastern Time.] Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
FAX	1-855-605-6385 for coverage determinations only
WRITE	Limited Income NET Program P.O. Box 14310 Lexington, KY 40512-4310
WEBSITE	Humana.com/LINET

Method	Appeals for Part D Prescription Drugs - Contact Information
CALL	1-800-783-1307 Calls to this number are free. You can call us [Monday through Friday 8 a.m. to 7 p.m., Eastern Time.] Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
FAX	1-877-556-7005
WRITE	Limited Income NET Program P.O. Box 14165 Lexington, KY 40512-4165

Method	Appeals for Part D Prescription Drugs - Contact Information
WEBSITE	Humana.com/LINET

How to contact us when you are making a complaint

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints – Contact Information
CALL	1-800-783-1307 Calls to this number are free. You can call us [Monday through Friday 8 a.m. – 7 p.m., Eastern Time.] Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
FAX	1-877-556-7005
WRITE	Limited Income NET Program P.O. Box 14165 Lexington, KY 40512-4165
WEBSITE	You can submit a complaint about LI NET directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. If you have received a bill or paid for drugs (such as a pharmacy bill) that you think we should pay for, you may need to ask the plan for reimbursement or to pay the pharmacy bill, see Chapter 5 (*Asking us to pay our share of the costs for covered drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can

appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	1-800-783-1307 Calls to this number are free. You can call us [Monday through Friday 8 a.m. – 7 p.m., Eastern Time.] Customer Care also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
FAX	1-877-210-5592
WRITE	Limited Income NET Program P.O. Box 14310 Lexington, KY 40512-4310
WEBSITE	Humana.com/LINET

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Prescription Drug Plans, including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

Method	Medicare – Contact Information
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool: Provides** Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about LI NET: • **Tell Medicare about your complaint:** You can submit a complaint about LI NET directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Contact information for your State Health Insurance Assistance Program (SHIP) can be found in "Exhibit A" in the back of this document.

The State Health Insurance Assistance Program (SHIP) is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit http://www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Contact information for your state Quality Improvement Organization can be found in "Exhibit A" in the back of this document.

The Quality Improvement Organization (QIO) has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare.

You should contact your QIO if you have a complaint about the quality of care you have received. For example, you can contact your QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare.

U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov/

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB)**: Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB)**: Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid office. Contact information for your state Medicaid office can be found in "Exhibit A" in the back of this document.

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments and coinsurance. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (See Section 6 of this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- If you already have a document that proves you have qualified for "Extra Help," you can also show it the next time you go to a pharmacy to have a prescription filled. You can use any one of the following documents to provide evidence to us, or to show as proof at the pharmacy.

Proof that you already have "Extra Help" status

- A copy of your Medicaid card showing your name and the date you became eligible for "Extra Help" The date has to be in the month of July or later of last year.
- A letter from the Social Security Administration showing your "Extra Help" status. This letter could be called Important Information, Award Letter, Notice of Change, or Notice of Action.

Proof that you have active Medicaid Status

- A copy of any state document or any printout from the state system showing your active Medicaid status. The active date shown has to be in the month of July or later of last year.

Proof of payment for a stay at a medical facility

Your stay at the medical facility must be at least one full month long, and must be in the month of July or later of last year.

- A billing statement from the facility showing the Medicaid payment
- A copy of the any state document or printout from the state system showing the Medicaid payment for you

If you first show one of the documents listed above as proof at the pharmacy, please also send us a copy. Mail or fax the document to:

Limited Income NET Program
P.O. Box 14310
Lexington, KY 40512-4310
Fax: 1-877-210-5592

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Care if you have questions.

What if you have Extra Help and coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the ADAP operating in your state.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP. Contact information for your

state ADAP can be found in "Exhibit A" in the back of this document.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

You can contact your State Pharmaceutical Assistance Program for more information. Contact information for your State Pharmaceutical Assistance Program can be found in "Exhibit A" in the back of this document.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 9 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the

enrollment period. (Phone numbers for Customer Care are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3:

Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter explains rules for using your coverage for Part D drugs.

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2025* handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You can use any pharmacy to fill your prescription. (See Section 2 in this chapter.)
- Your drug must be used for a *medically accepted indication*. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 of this chapter for more information about restrictions on your coverage.)

SECTION 2 Fill your prescription at any pharmacy

Section 2.1 Use any pharmacy

In most cases, your prescriptions are covered at any pharmacy.

The term *covered drugs* means Part D prescription drugs that are covered by Medicare.

Section 2.2 Specialized pharmacies

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, call Customer Care.

Section 2.3 Requesting reimbursement from the plan

How do you ask for reimbursement from the plan?

If you pay the full cost (rather than your normal cost share) at the time you fill your prescription, you can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be Part D eligible drugs

Section 3.1 All Part D drugs are covered

LI NET has an open formulary, therefore any drug covered under Medicare Part D is covered by the plan.

We will generally cover a drug covered under Medicare Part D as long as you follow the other coverage rules explained in this chapter and the drug is used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed, or.
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The plan covers brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to *drugs*, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 10 for definitions of the types of drugs that may be on the Drug List.

What is *not* covered?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more about this, see Section 7.1 in this chapter.)

Section 3.2 There are two cost-sharing tiers for drugs on the Drug List

Every drug is in one of two cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-Sharing Tier 1 includes generic drugs and is the lowest cost-sharing tier.
- Cost-Sharing Tier 2 includes brand drugs and is the highest cost-sharing tier.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way.

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Care to learn what you or your provider would need to do to get coverage for the drug. **If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (See Chapter 7.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan, based on specific criteria, before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not covered or is covered with restrictions. For example:

- The drug might not be covered at all..
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. **If your drug is not covered or if your drug is restricted, go to Section 5.2 to learn what you can do.**

Section 5.2 What can you do if your drug is not on the covered or if the drug is restricted in some way?

If your drug is not on covered or is restricted, here are options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may

work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes occur, we post information on our website about those changes. This section describes the types of changes we may make to and when you will get direct notice if changes are made for a drug that you are taking.

Changes we may make that affect you during the current plan year

- **Removing unsafe drugs and other drugs that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If you are taking that drug, we will tell you.
- **Making changes to covered drugs.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 7.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are *excluded*. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in "Exhibit A" in the back of this document.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your confirmation of enrollment letter, to any pharmacy you choose. The pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your confirmation of enrollment letter with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility?

If you are admitted to a hospital or to a skilled nursing facility, Original Medicare (or your Medicare health plan with Part A and B coverage, if applicable) will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in LI NET doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through LI NET in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or LI NET for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is creditable, and the choices you have for drug coverage. (If the coverage from the Medigap policy is creditable, it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 What if you are in Medicare-certified Hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

CHAPTER 4:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.**

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3, Sections 1 through 4 explain these rules.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called *cost sharing*, and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3):

- The amount you pay for drugs when you are in the following drug payment stages:
  - The Initial Coverage Stage

- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, employer or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of *$2,000* in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan]
- Payments for your drugs that are made by the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Care.

How can you keep track of your out-of-pocket total?

- We will help you. The *Smart Summary* you receive includes the current amount of your out-of-pocket costs. When this amount reaches *$2,000* this report will tell you that you

have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.

- Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for LI NET members?

There are two **drug payment stages** for your prescription drug coverage under LI NET. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Initial Coverage Stage

Stage 2: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *SmartSummary*

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *SmartSummary*. The *SmartSummary* includes:

- **Information for that month.** This report gives the payment details about the

prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your confirmation of enrollment letter every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug from a pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have paid the full price for a covered drug under special circumstances.
  - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *SmartSummary*, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call Customer Care. Be sure to keep these reports.

SECTION 4 There is no deductible for LI NET

There is no deductible for LI NET. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has *two* cost-sharing tiers

Every covered drug is in one of two cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1: includes generic drugs and is the lowest cost-sharing tier.
- Cost-Sharing Tier 2: includes brand drugs and is the highest cost-sharing tier.

Your pharmacy choices

Use any pharmacy to fill your prescriptions.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be a copayment.

As shown in the table below, the amount of the copayment depends on the cost-sharing tier. Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Extra Help Level 1	Extra Help Level 2	Extra Help Level 3
Cost-Sharing Tier 1 *(Generic)*	**$4.90**	**$1.60**	**$0.00**

Tier	Extra Help Level 1	Extra Help Level 2	Extra Help Level 3
Cost-Sharing Tier 2 *(Brand)*	**$12.15**	**$4.80**	**$0.00**

Please see Section 7 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the *daily cost-sharing rate*) and multiply it by the number of days of the drug you receive.

Section 5.4 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach *$2,000*

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000 You then move on to the Catastrophic Coverage Stage.

The *SmartSummary* that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Not all members will reach the *$2,000* out-of-pocket limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the

$2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs

SECTION 7 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. Our plan covers most adult Part D vaccines at no cost to you. Contact Customer Care for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the **vaccine itself.**
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.

2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at a pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost, by using the procedures that are described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine (including administration)

Situation 3: You buy the Part D vaccine itself from the pharmacy, and then take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid.

CHAPTER 5:

Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called *reimbursing* you). There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7).

1. When you pay the full cost for a prescription because you don't have your confirmation of enrollment letter with you

If you do not have your confirmation of enrollment letter with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within *36 months*** of the date you received the service, item, or drug.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (humana.com/LINET) or Customer Care and ask for the form.

Mail or fax your request for payment together with any bills or paid receipts to us at this address:

Limited Income NET Program

P.O. Box 14310

Lexington, KY 40512-4310

Fax: 1-877-210-5592

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. We will send payment within 30 days after your request was received.

- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with LI NET at 1-800-783-1307. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de manera competente desde el punto de vista cultural y sean accesibles para todos los afiliados, incluidos aquellos con dominio limitado del inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con orígenes culturales y étnicos diversos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, telemáquinas de escribir o conexión TTY (teléfono de texto o teléfono de telemáquina).

Nuestro plan cuenta con servicios gratuitos de intérpretes disponibles para responder preguntas de afiliados discapacitados y de los que no hablan inglés.

También podemos darle información en braille, en letra grande o en otros formatos alternativos sin costo en caso de ser necesario. Se nos exige darle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de parte de nosotros de una forma que se ajuste a sus necesidades, llame a servicios a los miembros.

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado, llame para presentar una queja formal ante el Departamento de quejas formales y apelaciones de LI NET al 1-800-783-1307, TTY 711.

También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered drugs

You have the right to get your prescriptions filled or refilled at any pharmacy without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your

records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Care.

Insurance ACE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at https://huma.na/insuranceace

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?

Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term “information” in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others.

For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus,

and the Medical Information Bureau.

What information do we receive about you?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

How do we protect your information?

We have a responsibility to protect the privacy of your information in all formats including electronic and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy programs and procedures

How do we use and disclose your information?

We use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information to:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For preforming underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment, and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment

reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.

- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if, the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or an caregiver call us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may revoke your permission at any time by notifying us in writing.

The following uses and disclosures will require your written permission:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of protected health information

What do we do with your information when you are no longer a member?

Your information may continue to be used for purposes described in this notice.

This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

We are committed to responding to your rights request in a timely manner

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision – If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if reasonable.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute. *
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice – You have the right to request and receive a written copy of this notice any time.
- Restriction – You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

*This applies to our Massachusetts residents in accordance with state regulations.

If I believe my privacy has been violated, what should I do?

If you believe that your privacy has been violated, you may file a complaint with us by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR).

We will give you the appropriate OCR regional address on request. You can e-mail your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you.

The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our website at Humana.com and going to the Privacy Practices link
- Send completed request form to:

Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

Section 1.4 We must give you information about the plan and your covered drugs

As a member of LI NET, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Care.

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state's Quality Improvement Organization (QIO). Contact information can be found in "Exhibit A" in the back of this document.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly.**

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Care**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call **Customer Care**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare.**
  - You can visit the Medicare website to read or download the publication Medicare Rights & Protections. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan confirmation of enrollment letter whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Pay what you owe.** As a plan member, you are responsible for these payments:

  For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you** cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Customer Care for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected

with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in "Exhibit A" in the back of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether prescription drugs are covered or not, the way they are covered, and problems related to payment for prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for prescription drugs, including payments. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can *appeal* the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or *fast appeal* of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Part D appeals are discussed further in Section 5 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 6 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Care.**
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Customer Care and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS- Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

- **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug or Part D* drug every time.
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization) **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

Legal Term
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception**.

If a drug is not covered in the way you would like it to be covered, you can ask us to make an *exception*. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved.

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A fast coverage decision is called an **expedited coverage determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you have *not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the *supporting statement,*** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer within **24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A *fast appeal* is also called an **expedited redetermination**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you are appealing a decision, we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a *fast appeal*.
- The requirements for getting a fast appeal are the same as those for getting a *fast coverage decision* in Section 5.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** (1-800-783-1307 TTY: 711). Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website Humana.com/LINET. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the

information about your coverage request. We check to see if we were following all the rules when we said no to your request.

- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 5.6 Step-by-step: How to make a Level 2 appeal

Legal Term
The formal name for the *independent review organization* is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare.** It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your **case file. You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a *fast appeal*.
- If the organization agrees to give you a *fast appeal*, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug, you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must **provide the drug coverage** that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the** independent review organization says yes to part or all of your request to pay you back **for a drug you already bought, we are required to** send payment to you within 30 calendar days **after we receive the decision from the review organization**.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called *upholding the decision.* It is also called *turning down your appeal.*) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal **An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 7.1 What kinds of problems are handled by the complaint process?

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Care or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms
• A **Complaint** is also called a **grievance.** • **Making a complaint** is also called **filing a grievance.** • **Using the process for complaints** is also called **using the process for filing a grievance.** • A **fast complaint** is also called an **expedited grievance.**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- Grievance Filing Instructions File a verbal grievance by calling Customer Care at 1-800-783-1307 TTY 711.

  Send a written grievance to:

  Limited Income NET Program
  P.O. Box 14310
  Lexington, KY 40512-4310

When filing a grievance, please provide:

□ Name

□ Address

□ Telephone number

□ Member identification number

□ A summary of the complaint and any previous contact with us related to the complaint

□ The action you are requesting from us

□ A signature from you or your authorized representative and the date. If you want a friend, relative, your doctor, or other person to be your representative, call Customer Care and ask for the Appointment of Representative form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give a us a copy of the signed form.

- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.

- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- **If you are making a complaint because we denied your request for a *fast coverage decision* or a *fast appeal*, we will automatically give you a *fast complaint*.** If you have a *fast complaint*, it means we will give you an answer **within 24 hours.**

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to

Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 7.5 Step-by-step: Making a complaint

You can submit a complaint about LI NET directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in LI NET may be **voluntary** (your own choice) or **involuntary** (not your own choice)

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 4 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 How can you end your membership in our plan?

You can end your membership in our plan by calling Customer Care at 1-800-783-1307 TTY 711. Keep in mind once your membership has ended, Medicare will no longer pay for your drugs until you enroll in another Medicare prescription drug plan.

SECTION 3 Until your membership ends, you must keep getting your drugs through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your prescription drugs through our plan.

- **Continue to use any pharmacy to get your prescriptions filled.**

SECTION 4 LI NET must end your membership in the plan in certain situations

Section 4.1 When must we end your membership in the plan?

LI NET must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and

that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Customer Care.

Section 4.2 We cannot ask you to leave our plan for any health-related reason

LI NET is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Section 4.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you file a grievance or can make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, LI NET as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

Our right to recover payment.

If we pay a claim for you, we have subrogation rights. This is a very common insurance provision that means we have the right to recover the amount we paid for your claim from any

third party that is responsible for the medical expenses or benefits related to your injury, illness, or condition.

You assign to us your right to take legal action against any responsible third party, and you agree to:

1. Provide any relevant information that we request; and

2. Participate in any phase of legal action, such as discovery, depositions and trial testimony, if needed.

If you don't cooperate with us or our representatives, or you do anything that interferes with our rights, we may take legal action against you. You also agree not to assign your right to take legal action to someone else without our written consent.

Our right of reimbursement

We also have the right to be reimbursed if a responsible third part pays you directly. If you receive any amount as a judgement, settlement, or other payment from any third party, you must immediately reimburse us, up to the amount we paid for your claim.

Our rights take priority

Our rights of recovery and reimbursement have priority over other claims, and will not be affected by any equitable doctrine. This means that we're entitled to recover the amount we paid, even if you haven't been compensated by the responsible third party for all costs related to your injury or illness. If you disagree with our efforts to recover payment, you have the right to appeal, as explained in Chapter 7.

We are not obligated to pursue reimbursement or take legal action against a third party, either for our own benefit or on your behalf. Our rights under Medicare law and this *Evidence of Coverage* will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition.

SECTION 5 Notice of coordination of benefits

Why do we need to know if you have other coverage?

We coordinate benefits in accordance with Medicare Secondary Payer rules, which allow us to bill, or authorize a provider of services to bill, other insurance carriers, plans, policies, employers, or other entities when the other payer is responsible for payment of services provided to you. We are also authorized to charge or bill you for amounts the other payer has already paid to you for such services. We shall have all rights accorded to the Medicare Program under the Medicare Secondary Payer rules.

Who pays first when you have other coverage?

When you have additional coverage, how we coordinate your coverage depends on your situation. With coordination of benefits, you will often get your care as usual through our plan providers, and the other plan or plans you have will simply help pay for the care you receive. If you have group health coverage, you may be able to maximize the benefits available to you if you use providers who participate in your group plan and our plan. In other situations, such as for benefits that are not covered by our plan, you may get your care outside of our plan.

Employer and employee organization group health plans

Sometimes, a group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You have coverage under a group health plan (including both employer and employee organization plans), either directly or through your spouse, and
- The employer has twenty (20) or more employees (as determined by Medicare rules), and
- You are not covered by Medicare due to disability or End-Stage Renal Disease (ESRD).

If the employer has fewer than twenty (20) employees, generally we will provide your primary health benefits. If you have retiree coverage under a group health plan, either directly or through your spouse, generally we will provide primary health benefits. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people who are disabled

If you have coverage under a group health plan, and you have Medicare because you are disabled, generally we will provide your primary health benefits. This happens if:

- You are under age 65, and
- You do not have ESRD, and
- You don’t have coverage directly or through your spouse under a large group health plan.

A large group health plan is a health plan offered by an employer with 100 or more employees, or by an employer who is part of a multiple-employer plan where any employer participating in the plan has 100 or more employees.

If you have coverage under a large group health plan, either directly or through your spouse, your large group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You do not have ESRD, and
- Are under age 65 and have Medicare based on a disability.

In such cases, we will provide only those benefits not covered by your large employer group plan. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people with End-Stage Renal Disease (ESRD)

If you are or become eligible for Medicare because of ESRD and have coverage under an employer or employee organization group health plan, either directly or through your spouse, your group health plan is responsible for providing primary health benefits to you for the first thirty (30) months after you become eligible for Medicare due to your ESRD. We will provide secondary coverage to you during this time, and we will provide primary coverage to your thereafter. If you are already on Medicare because of age or disability when you develop ESRD, we will provide primary coverage.

Workers' Compensation and similar programs

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, workers' compensation must provide its benefits first for any healthcare costs related to your job-related illness or injury before we will provide any benefits under this *Evidence of Coverage* for services rendered in connection with your job-related illness or injury.

Accidents and injuries

The Medicare Secondary Payer rules apply if you have been in an accident or suffered an injury. If benefits under "Med Pay," no-fault, automobile, accident, or liability coverage are available to you, the "Med Pay," no-fault, automobile, accident, or liability coverage carrier must provide its benefits first for any healthcare costs related to the accident or injury before we will provide any benefits for services related to your accident or injury.

Liability insurance claims are often not settled promptly. We may make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In these situations, our payments are conditional. Conditional payments must be refunded to us upon receipt of the insurance or liability payment.

If you recover from a third party for medical expenses, we are entitled to recovery of payments we have made without regard to any settlement agreement stipulations. Stipulations that the settlement does not include damages for medical expenses will be disregarded. We will recognize allocations of liability payments to non-medical losses only when payment is based on a court order on the merits of the case. We will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

Non-duplication of benefits

We will not duplicate any benefits or payments you receive under any automobile, accident, liability, or other coverage. You agree to notify us when such coverage is available to you, and

it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability, or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, or liability coverage or other carrier.

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to section 4 of this chapter, Additional Notice about Subrogation (Recovery from a Third Party) for more information on our recovery rights.

More information

This is just a brief summary. Whether we pay first or second - or at all - depends on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government called "*Medicare & Other Health Benefits: Your Guide to Who Pays First.*" It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the *Code of Federal Regulations*.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 7 *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* in this *Evidence of Coverage*.

CHAPTER 10:
Definitions of important words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,000 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for prescription drugs.

Complaint – The formal name for *making a complaint is filing a grievance*. The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed *copayment* amount that a plan requires when a specific drug is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of two cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called *coverage decisions* in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Customer Care - A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A *daily cost-sharing rate* may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your daily *cost-sharing rate* is $1 per day.

Deductible – The amount you must pay for prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a *generic* drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Low Income Subsidy (LIS) – See "Extra Help."

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's *out-of-pocket* cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get certain drugs.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area where you must live to join a particular prescription drug plan. The plan may disenroll you if you permanently move out of the plan's service area.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Exhibit A

State Agency contact information

State Agency Contact Information

This section provides the contact information for the state agencies referenced in Chapter 2 and in other locations within this Evidence of Coverage. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

Alabama	
SHIP Name and Contact Information	Alabama Department of Senior Services 201 Monroe Street Suite 350 Montgomery, AL 36104 1-877-425-2243 (toll free) 1-334-242-5594 (fax) http://www.alabamaageline.gov/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-305-6759 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Alabama Medicaid Agency 501 Dexter Avenue P.O Box 5624 Montgomery, AL 36104-5624 1-800-362-1504 (toll free) 1-334-242-5000 (local) http://www.medicaid.alabama.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Alabama AIDS Drug Assistance Program, HIV/AIDS Division, Alabama Department of Public Health The RSA Tower 201 Monroe Street Suite 1400 Montgomery, AL 36104 1-866-574-9964 http://www.alabamapublichealth.gov/hiv/adap.html

Alaska	
SHIP Name and Contact Information	Alaska State Health Insurance Assistance Programs (SHIP) 550 W 7th Ave., Suite 1230 Anchorage, AK 99501 1-800-478-6065 (toll free) 1-907-269-7800 (local) 1-800-770-8973 (TTY) (toll free) https://dhss.alaska.gov/pages/default.aspx
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-305-6759 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Alaska Department of Health and Social Services 350 Main Street Room 304 P.O. Box 110640 Juneau, AK 99811 1-800-780-9972 (toll free) 1-907-465-3030 (local) 1-907-465-3068 (fax) http://dhss.alaska.gov/dpa
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Alaskan AIDS Assistance Association 1057 W. Fireweed Lane, Ste 102 Anchorage, AK 99503 1-800-478-2437 1-907-263-2051 (fax) http://www.alaskanaids.org/index.php/client-services/adap

Arizona	
SHIP Name and Contact Information	Arizona State Health Insurance Assistance Program (SHIP) 1789 W. Jefferson St. (Site Code 950A) Phoenix, AZ 85007 1-800-432-4040 (toll free) (Spanish available upon request) 1-602-542-4446 (local) 711 (TTY) https://des.az.gov/services/older-adults/medicare-assistance
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-855-694-2929 (Fax) https://livantaqio.com/
State Medicaid Office	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson St. Phoenix, AZ 85034 1-800-523-0231 (toll free) 1-602-417-4000 (local) 1-602-252-6536 (fax) 1-602-417-4000 (Spanish) http://www.azahcccs.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Office of Disease Integration and Services Arizona Department of Health Services 150 North 18th Avenue Phoenix, AZ 85007 1-800-334-1540 1-602-364-3263 (fax) 1-602-364-3610 http://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home

Arkansas	
SHIP Name and Contact Information	Senior Health Insurance Information Program (SHIIP) 1 Commerce Way Little Rock, AR 72202 1-800-224-6330 (toll free) 1-501-371-2782 (local) 1-501-371-2618 (Fax) 1-501-683-4468 (TTY) https://www.shiipar.com/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Arkansas Medicaid Donaghey Plaza South PO Box 1437, Slot S401 Little Rock, AR 72203-1437 1-800-482-5431 (toll free) 1-501-682-8233 (local) 1-800-482-8988 (Spanish) 1-501-682-8820 (TTY) https://humanservices.arkansas.gov/divisions-shared-services/medical-services
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Arkansas AIDS Drug Assistance Program Arkansas Department of Health, HIV/STD/Hepatitis C, ADAP Division 4815 West Markham Street Slot 33 Little Rock, AR 72205 1-501-661-2408 1-501-661-2082 (fax) 1-800-462-0599 https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program

California	
SHIP Name and Contact Information	California Health Insurance Counseling & Advocacy Program (HICAP) 1300 National Drive Suite 200 Sacramento, CA 95834-1992 1-800-434-0222 (toll free) 1-916-928-2267 (Fax) 1-800-735-2929 (TTY) https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-855-694-2929 (Fax) https://livantaqio.com/
State Medicaid Office	Medi-Cal (Medicaid) PO Box 997413, MS 4401 Sacramento, CA 95899-7413 1-800-541-5555 (toll free) 1-916-636-1980 (local) 711 (TTY) http://www.medi-cal.ca.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Aids Drug Assistance Program California Department of Public Health, Center for Infectious Diseases, Office of AIDS MS 0500, P.O. Box 997377 Sacramento, CA 95899 1-916-558-1784 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx

Colorado	
SHIP Name and Contact Information	Senior Health Insurance Assistance Program (SHIP) Colorado Division of Insurance 1560 Broadway, Suite 850 Denver, CO 80202 1-800-930-3745 (toll free) 1-303-894-7499 (local) https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0891 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Health First Colorado (Medicaid) 303 E. 17th Avenue Denver, CO 80203-1818 1-800-221-3943 (toll free) 1-303-866-2993 (local) 1-303-866-4411 (fax) 711 (TTY) https://www.healthfirstcolorado.com/
State Pharmacy Assistance Programs	Colorado Bridging the Gap Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246 1-303-692-2687 (local) 1-303-692-2716 (local) https://cdphe.colorado.gov/state-drug-assistance-program
AIDS Drug Assistance Program	Colorado State Drug Assistance Program CDPHE Care and Treatment Program ADAP - 3800 4300 Cherry Creek Drive South Denver, CO 80246 1-303-692-2000 https://cdphe.colorado.gov/state-drug-assistance-program

Connecticut	
SHIP Name and Contact Information	CHOICES 55 Farmington Avenue Hartford, CT 06105-3730 1-800-994-9422 (toll free) 1-860-424-5055 1-860-247-0775 (TTY) 1-860-424-4850 (Fax) https://portal.ct.gov/ADS-CHOICES
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0891 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	HUSKY Health Connecticut (Medicaid) 55 Farmington Avenue Hartford, CT 06105-3730 1-855-626-6632 (toll free) 1-800-842-4524 (TYY) https://portal.ct.gov/dsshome
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Connecticut AIDS Drug Assistance Program (CADAP) No physical address for ADAP program, administered by MagellanRx Connecticut Department of Public Health 410 Capitol Ave. Hartford, CT 06134 1-800-424-3310 (toll free) 1-800-424-7462 (fax) https://ctdph.magellanrx.com/

Delaware	
SHIP Name and Contact Information	Delaware Medicare Assistance Bureau (DMAB) 1351 West North Street Suite 101 Dover, DE 19904 1-800-336-9500 (toll free) 1-302-674-7300 (local) https://insurance.delaware.gov/divisions/dmab/

Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 N. DuPont Highway New Castle, DE 19720 1-800-372-2022 (toll free) 1-302-255-9500 (local) 1-302-255-4429 (fax) https://www.dhss.delaware.gov/dhss/dmma/
State Pharmacy Assistance Programs	Delaware Prescription Assistance Program 11-13 North Church Ave Milford, DE 19963-0950 1-800-996-9969 (toll free) 1-302-424-7180 https://www.dhss.delaware.gov/dhss/dmma/dpap.html
AIDS Drug Assistance Program	Delaware AIDS Drug Assistance Program (ADAP) Thomas Collins Building 540 S. DuPont Highway Dover, DE 19901 1-302-744-1050 1-302-739-2548 (fax) http://www.ramsellcorp.com/medical_professionals/de.aspx

District of Columbia	
SHIP Name and Contact Information	Health Insurance Counseling Project (HICP) 500 K Street NE Washington, DC 20002 1-202-724-5626 (local) 711 (TTY) 1-202-724-2008 (fax) https://dacl.dc.gov/service/health-insurance-counseling

Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Department of Health- District of Columbia 899 North Capitol Street NE Washington, DC 20002 1-855-532-5465 (toll free) 1-202-442-5955 (local) 1-202-442-4795 (fax) 711 (TTY) http://doh.dc.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	DC AIDS Drug Assistance Program District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration, AIDS Drugs Assistance Program 899 North Capitol Street N.E. Washington, DC 20002 1-202-671-4900 1-202-673-4365 (fax) 1-202-671-4815 (DC ADAP Hotline) https://dchealth.dc.gov/DC-ADAP

Florida	
SHIP Name and Contact Information	Serving Health Insurance Needs of Elders (SHINE) Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399- 7000 1-800-963-5337 (toll free) 1-800-955-8770 (TTY) 1-850-414-2150 (fax) 1-800-963-5337 http://www.floridaSHINE.org

Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Florida Medicaid 2727 Mahan Drive Tallahassee, FL 32308-5407 1-888-419-3456 (toll free) 1-850-412-4000 (local) 1-850-922-2993 (fax) 1-800-955-8771 (TTY) https://ahca.myflorida.com
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Florida AIDS Drug Assistance Program (ADAP) HIV/AIDS Section 4052 Bald Cypress Way Tallahassee, FL 32399 1-850-245-4422 1-800-545-7432 (1-800-545-SIDA) (Spanish) 1-800-2437-101 (1-800-AIDS-101) (Creole) 1-888-503-7118 (TTY) http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html

Georgia	
SHIP Name and Contact Information	GeorgiaCares 47 Trinity Ave SW Atlanta, GA 30334 1-866-552-4464 (Option 4) 1-404-657-1929 (TTY) 1-404-657-5285 (fax) https://aging.georgia.gov/georgia-ship

Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Georgia Department of Community Health (DCH) (Medicaid) 2 Martin Luther King Jr Drive, SE Atlanta, GA 30334 1-800-436-7442 (toll free) 1-404-656-4507 (local) http://www.dch.georgia.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Georgia AIDS Drug Assistance Program (ADAP) Georgia Department of Public Health, Health Protection, Office of HIV/AIDS 200 Piedmont Avenue, SE Atlanta, GA 30334 1-404-656-9805 https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap

Hawaii

SHIP Name and Contact Information	Hawaii SHIP Hawaii State Department of Health No. 1 Capitol District 250 South Hotel St. Suite 406 Honolulu, HI 96813-2831 1-888-875-9229 (toll free) 1-808-586-7299 (local) 1-808-586-0185 (fax) http://www.hawaiiship.org/
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-855-694-2929 (Fax) https://livantaqio.com/

State Medicaid Office	Med QUEST 801 Dillingham Boulevard 3rd Floor Honolulu, HI 96817-4582 1-800-316-8005 (toll free) 1-808-524-3370 (local) 1-800-603-1201 (TTY) 1-800-316-8005 (Spanish) http://www.med-quest.us/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	HIV Medical Management Services Harm Reduction Services Branch 728 Sunset Avenue Honolulu, HI 96816 1-808-733-4383 https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/

Idaho	
SHIP Name and Contact Information	Senior Health Insurance Benefit Advisors (SHIBA) 700 West State Street 3rd Floor P.O. Box 83720 Boise, ID 83720-0043 1-800-247-4422 (toll free) 1-208-334-4389 (fax) https://doi.idaho.gov/SHIBA
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-305-6759 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Idaho Health Plan Coverage P.O Box 83720 Boise, ID 83720 1-877-456-1233 (toll free) 1-208-334-6700 (local) 1-866-434-8278 (fax) http://healthandwelfare.idaho.gov/

State Pharmacy Assistance Programs	Idaho AIDS Drug Assistance Program (IDAGAP) Department of Health and Welfare P. O. Box 83720 Boise, ID 83720 1-800-926-2588 (toll free) 1-208-334-5943 (local) http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx
AIDS Drug Assistance Program	Idaho ADAP Idaho Ryan White Part B Program 450 W. State Street P.O. Box 83720 Boise, ID 83720 1-208-334-5612 1-208-332-7346 (fax) http://www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx

Illinois	
SHIP Name and Contact Information	Senior Health Insurance Program (SHIP) Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271 1-800-252-8966 (toll free) 1-888-206-1327 (TTY) https://ilaging.illinois.gov/ship.html
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Medical Assistance Program 100 South Grand Avenue East Springfield, IL 62762 1-800-843-6154 (toll free) 1-217-782-4977(local) 1-866-324-5553 (TTY) https://www.dhs.state.il.us
State Pharmacy Assistance Programs	Not Applicable

AIDS Drug Assistance Program	Ryan White CARE and HOPWA Services Illinois Medication Assistance Program 525 West Jefferson Street, 1st Floor Springfield, IL 62761 1-800-825-3518 1-217-785-8013 (fax) https://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services

Indiana	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) 311 W. Washington Street Suite 300 Indianapolis, IN 46204-2787 1-800-452-4800 (toll free) 1-765-608-2318 (local) 1-866-846-0139 (toll free TTY) http://www.in.gov/ship
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Indiana Medicaid 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46204-2243 1-800-457-4584 (toll free) 1-317-233-4454 (local) 1-800-403-0864 (Fax) https://www.in.gov/medicaid/
State Pharmacy Assistance Programs	Hoosier RX 402 W. Washington, Rm. 372 Indianapolis, IN 46204 1-866-267-4679 (toll free) 1-317-234-1381 (local) https://www.in.gov/medicaid/members/member-programs/hoosierrx/

AIDS Drug Assistance Program	Indiana AIDS Drug Assistance Program Indiana State Department of Health, HIV/STD Viral Hepatitis Division 2 N Meridian St. Suite 6C Indianapolis, IN 46204 1-800-382-9480 http://www.in.gov/health/

Iowa	
SHIP Name and Contact Information	Senior Health Insurance Information Program (SHIIP) Iowa Insurance Division 1963 Bell Avenue Suite 100 Des Moines, IA 50315 1-800-351-4664 (toll free) 1-800-735-2942 (toll free TTY) 1-515-654-6500 (Fax) https://shiip.iowa.gov/
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Iowa HHS (Medicaid) 1305 E Walnut St Des Moines, IA 50319-0114 1-800-338-8366 (toll free) 1-515-256-4606 (local) 1-515-725-1351 (fax) 1-800-735-2942 (TTY) http://dhs.iowa.gov/iahealthlink
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Care & Support Services - The Ryan White Part B Program Iowa Department of Public Health 321 E. 12th Street Des Moines, IA 50319 1-515-380-6942 (Holly Hanson, Coordinator) http://idph.iowa.gov/hivstdhep/hiv/support

Kansas	
SHIP Name and Contact Information	Senior Health Insurance Counseling for Kansas (SHICK) New England Building 503 S. Kansas Avenue Topeka, KS 66603-3404 1-800-860-5260 1-785-296-0256 (fax) 1-785-296-4986 (local) https://kdads.ks.gov/kdads-commissions/long-term-services-supports/aging-services/medicare-programs/shick
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	DCR (Formerly Department of Social and Rehabilitation Services of Kansas) Curtis State Office Building 1000 SW Jackson Topeka, KS 66612 1-800-766-9012 (toll free) 1-785-296-1500 (local) http://www.kdheks.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Kansas AIDS Drug Assistance Program (ADAP) Curtis State Office Building 1000 SW Jackson Suite 210 Topeka, KS 66612 1-785-296-6174 1-785-559-4225 (fax) https://www.kdhe.ks.gov/355/The-Ryan-White-Part-B-Program

Kentucky	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) 275 East Main Street, 3E-E Frankfort, KY 40621 1-877-293-7447 (toll free) 1-502-564-6930 (local) https://chfs.ky.gov/agencies/dail/Pages/ship.aspx
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Department for Medicaid Services (DMS) 275 East Main Street 6W-A Frankfort, KY 40621 1-800-635-2570 (toll free) 1-502-564-4321 (local) 711 (TTY) https://chfs.ky.gov/agencies/dms/Pages/default.aspx
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Kentucky HIV/AIDS Care Coordinator Program (KHCCP) Kentucky Cabinet for Public Health and Family Services 275 East Main Street HS2E-C Frankfort, KY 40621 502-564-6539 1-877-353-9380 (fax) 1-800-420-7431 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Louisiana	
SHIP Name and Contact Information	Senior Health Insurance Information Program (SHIIP) 1702 N. Third Street P.O. Box 94214 Baton Rouge, LA 70802 1-800-259-5300 (toll free) 1-225-342-5301 (local) 1-800-259-5301 http://www.ldi.la.gov/SHIIP/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Healthy Louisiana (Medicaid) Louisiana Department of Health 628 N. 4th Street Baton Rouge, LA 70802 1-888-342-6207 (toll free) 1-225-342-9500 (local) 1-877-523-2987 (Fax) https://ldh.la.gov/subhome/1
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Louisiana Health Access Program Department of Health & Hospitals Louisiana Health Access Program (LA HAP) 1450 Poydras St Suite 2136 New Orleans, LA 70112 1-504-568-7474 1-504-568-3157 (fax) http://www.lahap.org

Maine	
SHIP Name and Contact Information	Maine State Health Insurance Assistance Program (SHIP) 109 Capitol Street 11 State House Station Augusta, ME 04333 1-800-262-2232 (toll free) Maine relay 711 (TTY) 1-207-287-3005 (Fax) 1-207-287-3707 (local) https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Maine Department of Health and Human Services (Medicaid) 109 Capitol St. Augusta, ME 04333-0011 1-800-977-6740 (toll free) 1-207-287-3707 (local) 1-207-287-3005 (fax) 711 (TTY) http://www.maine.gov/dhhs/
State Pharmacy Assistance Programs	Maine Low Cost Drugs for the Elderly or Disabled Program Office of MaineCare Services 221 State Street Augusta, ME 04333 1-866-796-2463 https://www.maine.gov/dhhs/oms/member-resources/pharmacy-benefits

AIDS Drug Assistance Program	Maine Ryan White Program ADAP 40 State House Station Augusta, ME 04330 1-207-287-3747 1-207-287-3498 (fax) http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml

Maryland	
SHIP Name and Contact Information	Maryland Department of Aging -Senior Health Insurance Assistance Program (SHIP) 301 West Preston Street Suite 1007 Baltimore, MD 21201 1-800-243-3425 (toll free) 1-410-767-1100 (local) 1-844-627-5465 (out of state) 711 (TTY) https://aging.maryland.gov/Pages/state-health-insurance-program.aspx
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Maryland Medicaid Program 201 West Preston St. Baltimore, MD 21201-2399 1-800-638-3403 (toll free) https://health.maryland.gov/mmcp/Pages/home.aspx
State Pharmacy Assistance Programs	Maryland Senior Prescription Drug Assistance Program Maryland SPDAP c/o International Software Systems Inc. P.O. Box 749 Greenbelt, CT 20768-0749 1-800-551-5995 (toll free) 1-410-767-5000 (local) 1-800-877-5156 (toll free) 1-800-847-8217 (fax) http://marylandspdap.com

AIDS Drug Assistance Program	Maryland AIDS Drug Assistance Program 201 W. Preston Street Baltimore, MD 21201-2399 1-410-767-6500 1-410-333-2608 (fax) 1-877-463-3464 https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx

Massachusetts	
SHIP Name and Contact Information	Serving Health Information Needs of Elders (SHINE) Executive Office of Elder Affairs One Ashburton Place, 5 floor Boston, MA 02108 1-800-243-4636 (toll free) 1-617-727-7750 (local) 1-617-727-9368 (fax) 1-877-610-0241 (toll free TTY) https://www.mass.gov/health-insurance-counseling
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	MassHealth 100 Hancock Street 6th Floor Quincy, MA 02171 1-800-841-2900 (toll free) 1-800-497-4648 (TTY) http://www.mass.gov/masshealth
State Pharmacy Assistance Programs	Massachusetts Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0153 1-800-243-4636 ext. 2 (toll free) 1-508-793-1166 (fax) https://www.prescriptionadvantagema.org/

AIDS Drug Assistance Program	Massachusetts HIV Drug Assistance Program (HDAP) CRI 529 Main Street Suite 301 Charlestown, MA 02129 1-617-502-1700 1-617-502-1703 (fax) http://crine.org/hdap

Michigan	
SHIP Name and Contact Information	MMAP, Inc. 6105 West St. Joseph Hwy Suite 204 Lansing, MI 48917 1-800-803-7174 (toll free) www.mmapinc.org
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Michigan Department of Health and Human Services (Medicaid) 333 S. Grand Ave P.O. Box 30195 Lansing, MI 48909 1-800-642-3195 (toll free) 711 (TTY) https://www.michigan.gov/mdhhs
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Michigan Drug Assistance Program (MIDAP) Michigan Drug Assistance Program, HIV Care Section, Division of Health, Wellness and Disease Control 109 Michigan Avenue 9th Floor Lansing, MI 48913 1-888-826-6565 1-517-335-7723 (fax) 1-517-335-8376 https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program

Minnesota	
SHIP Name and Contact Information	Minnesota State Health Insurance Assistance Program/ Senior LinkAge Line Elmer L. Anderson Human Services 540 Cedar Street (Office Address) St. Paul, MN 55164 1-800-333-2433 (toll free) 1-651-431-2500 (local) 1-651-431-7453 (fax) https://mn.gov/senior-linkage-line/
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Department of Human Services of Minnesota - MinnesotaCare PO Box 64838 St. Paul, MN 55164-0838 1-800-657-3672 (toll free) 1-651-297-3862 (local) 1-651-282-5100 (fax) http://mn.gov/dhs/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	HIV: medication program (ADAP) HIV/AIDS Programs, Minnesota Department of Human Services PO Box 64972 St. Paul, MN 55164 1-651-431-2414 1-651-431-7414 (fax) https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

Mississippi	
SHIP Name and Contact Information	MS Dept of Human Services - Division of Aging & Adult Services 200 South Lamar St. Jackson, MS 39201 1-844-822-4622 (toll free) 1-601-359-4500 (local) http://www.mdhs.ms.gov/adults-seniors/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Mississippi Division of Medicaid 550 High Street Suite 1000 Jackson, MS 39201 1-800-421-2408 (toll free) 1-601-359-6050 (local) 1-601-359-6294 (fax) 1-228-206-6062 (Video Phone) http://www.medicaid.ms.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	HIV Care and Treatment Program Office of STD/HIV Care and Treatment Division P.O. Box 1700 Jackson, MS 39215 1-888-343-7373 1-601-362-4782 (fax) 1-601-362-4879 https://msdh.ms.gov/msdhsite/_static/14,13047,150.html

Missouri	
SHIP Name and Contact Information	Missouri SHIP 1105 Lakeview Avenue Columbia, MO 65201 1-800-390-3330 (toll free) 1-573-817-8300 (local) http://www.missouriclaim.org

Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-855-694-2929 (Fax) https://livantaqio.com/
State Medicaid Office	MO HealthNet (Medicaid) 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500 1-855-373-4636 (toll free) 1-573-751-3425 (local) 1-800-735-2966 (TTY) http://www.dss.mo.gov/mhd/
State Pharmacy Assistance Programs	Missouri RX Plan P.O. Box 6500 Jefferson City, MO 65102 1-800-375-1406 (toll free) 1-573-751-6963 https://dss.mo.gov/mhd/faq/pages/faqmo_rx.htm
AIDS Drug Assistance Program	Missouri AIDS Drug Assistance Program Bureau of HIV, STD, and Hepatitis, Missouri Department of Health & Senior Services PO Box 570 Jefferson City, MO 65102 1-573-751-6439 1-573-751-6447 (fax) 1-888-252-8045 http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

Montana	
SHIP Name and Contact Information	Montana State Health Insurance Assistance Program (SHIP) 1100 N Last Chance Gulch 4th Floor Helena, MT 59601 1-800-551-3191 (toll free) https://dphhs.mt.gov/sltc/aging/ship

Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0891 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Montana Department of Public Health and Human Services (Medicaid) 111 North Sanders Street Helena, MT 59601-4520 1-800-362-8312 (toll free) 1-406-444-1970 1-406-444-1861 (fax) http://www.dphhs.mt.gov/
State Pharmacy Assistance Programs	Montana Big Sky RX Program P.O. Box 202915 Helena, MT 59620-2915 1-866-369-1233 (toll free- In State) 1-406-444-1233 (local) 1-406-444-3846 (fax) http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky
AIDS Drug Assistance Program	Ryan White HIV/AIDS Program (RWHAP) Cogswell Building Room C-211 1400 Broadway Helena, MT 59620 1-406-444-3565 1-406-444-6842 (fax) https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog

Nebraska

SHIP Name and Contact Information	Nebraska Senior Health Insurance Information Program (SHIIP) The Nebraska Department of Insurance P.O. Box 95087 Lincoln, NE 68509-5807 1-800-234-7119 (toll free) 1-402-471-2201 1-402-471-4610 (fax) http://www.doi.nebraska.gov/shiip/

Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-855-694-2929 (Fax) https://livantaqio.com/
State Medicaid Office	Nebraska Department of Health and Human Services (Medicaid) 301 Centennial Mall South Lincoln, NE 68509 1-855-632-7633 (toll free) 1-402-471-3121 (local) 1-402-471-9209 (fax) 1-800-833-7352 (toll free TTY) http://dhhs.ne.gov/Pages/default.aspx
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Nebraska AIDS Drug Assistance Program Nebraska Department of Health & Human Services P.O. Box 95026 Lincoln, NE 68509 1-402-471-2101 https://dhhs.ne.gov/Pages/HIV-Care.aspx

Nevada	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) 3416 Goni Road, Suite D-132 Carson City, NV 89706 1-800-307-4444 (toll free) 1-775-687-4210 https://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-855-694-2929 (Fax) https://livantaqio.com/

State Medicaid Office	Department of Health and Human Services Division of Health Care Financing and Policy (Medicaid) 1100 E. William Street Suite 102 Carson City, NV 89701 1-877-638-3472 1-775-684-3600 (local) 711 (TTY) https://www.medicaid.nv.gov
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Nevada AIDS Drug Assistance Program Office of HIV/AIDS 2290 S. Jones Blvd Suite 110 Las Vegas, NV 89146 1-702-486-0768 (Sarah Cowan, NMAP/ADAP Coordinator 1-702-274-2453 https://endhivnevada.org/adap-nmap/

New Hampshire	
SHIP Name and Contact Information	NH SHIP - ServiceLink Aging and Disability Resource Center 129 Pleasant Street Concord, NH 03301-3857 1-866-634-9412 (toll free) 1-844-275-3447 https://www.servicelink.nh.gov/medicare/index.htm
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	New Hampshire Medicaid 129 Pleasant Street Concord, NH 03301 1-844-275-3447 (toll free) 1-603-271-4344 (local) 1-800-735-2964 (toll free TTY) https://www.dhhs.nh.gov/

State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	New Hampshire AIDS Drug Assistance Program DHHS- NH CARE Program 29 Hazen Drive Concord, NH 03301 1-800-852-3345 1-603-271-9000 http://www.dhhs.nh.gov

New Jersey	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 1-800-792-8820 (toll free) 1-877-222-3737 https://nj.gov/humanservices/doas/services/q-z/ship/
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-866-815-5440 1-866-868-2289 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	NJ Family Care P.O. Box 712 Trenton, NJ 08625-0712 1-800-356-1561 (toll free) 1-877-294-4356 (TTY) http://www.state.nj.us/humanservices/dmahs
State Pharmacy Assistance Programs	New Jersey Senior Gold Prescription Discount Program New Jersey Department of Health and Senior Services Senior Gold Discount Program P.O. Box 715 Trenton, NJ 08625 1-800-792-9745 (toll free) https://nj.gov/humanservices/doas/services/q-z/senior-gold/

AIDS Drug Assistance Program	AIDS Drug Distribution Program (ADDP) New Jersey ADDP Office PO Box 722 Trenton, NJ 08625 1-877-613-4533 1-609-588-7037 (fax) https://www.nj.gov/health/hivstdtb/hiv-aids/medica

New Mexico	
SHIP Name and Contact Information	New Mexico ADRC 2550 Cerrillos Road Santa Fe, NM 87505 1-800-432-2080 (toll free) 1-505-476-4937 (TTY) http://www.nmaging.state.nm.us/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Department of Human Services of New Mexico P.O. Box 2348 Santa Fe, NM 87504-2348 1-888-997-2583 (toll free) 1-505-827-3100 (local) 1-800-432-6217 (Spanish) 1-855-227-5485 (TTY) http://www.newmexico.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	New Mexico AIDS Drug Assistance Program HIV Services Program 1190 S St. Francis Drive Suite 2-1200 Santa Fe, NM 87502 1-505-476-3628 1-505-827-0561 (fax) 1-833-796-8773 https://nmhealth.org/about/phd/idb/hats/

New York	
SHIP Name and Contact Information	Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, 5th Floor Albany, NY 12223 1-800-432-2080 (toll free) https://aging.ny.gov/health-insurance-information-counseling-and-assistance
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-866-815-5440 1-866-868-2289 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	New York State Department of Health (SDOH) (Medicaid) Office of Medicaid Management 800 North Pearl Street Albany, NY 12204 1-800-541-2831 (toll free) 1-518-473-3782 (local) https://www.health.ny.gov/health_care/medicaid/members/
State Pharmacy Assistance Programs	New York State Elderly Pharmaceutical Insurance Coverage (EPIC) EPIC P.O. Box 15018 Albany, NY 12212-5018 1-800-332-3742 (toll free) https://www.health.ny.gov/health_care/epic/
AIDS Drug Assistance Program	New York AIDS Drug Assistance Program HIV Uninsured Care Programs Empire Station P.O. Box 2052 Albany, NY 12220 1-800-542-2437 http://www.health.ny.gov/diseases/aids/general/resources/adap

North Carolina	
SHIP Name and Contact Information	Seniors' Health Insurance Information Program (SHIIP) 3200 Beechleaf Court Raleigh, NC 27604 1-855-408-1212 (toll free) 1-919-807-6900 1-919-807-6800 https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	North Carolina, Division of Health Benefits (Medicaid) 2501 Mail Service Center Raleigh, NC 27699-2101 1-800-662-7030 (toll free) 1-919-855-4100 (local) 1-919-733-6608 (fax) https://dma.ncdhhs.gov/
State Pharmacy Assistance Programs	North Carolina HIV SPAP 1902 Mail Service Center Raleigh, NC 27699-1902 1-877-466-2232 (toll free) 1-919-733-3419 (local) 1-919-733-0490 (fax) https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html
AIDS Drug Assistance Program	HIV Medication Assistance Program (HMAP) NC Department of Health and Human Services Division of Public Health, Epidemiology Section Communicable Disease Branch 1907 Mail Service Center Raleigh, NC 27699 1-877-466-2232 1-919-733-9161 1-919-715-7540 http://epi.publichealth.nc.gov/cd/hiv/hmap.html

North Dakota	
SHIP Name and Contact Information	Senior Health Insurance Counseling (SHIC) North Dakota Insurance Department 600 East Boulevard Ave. Bismarck, ND 58505-0320 1-888-575-6611 (toll free) 1-701-328-2440 (local) 1-800-366-6888 (TTY) https://www.insurance.nd.gov/consumers/medicare-assistance
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	North Dakota Medicaid 600 East Boulevard Ave Dept 325 Bismarck, ND 58505-0250 1-800-755-2604 (toll free) 1-701-328-7068 (local) 1-701-328-1544 (fax) 1-800-366-6888 (TTY) https://www.hhs.nd.gov/healthcare/medicaid
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	North Dakota AIDS Drug Assistance Program North Dakota Department of Health, Division of Disease Control 2635 E. Main Avenue P.O. Box 5520 Bismarck, ND 58506-5520 1-701-328-6272 1-701-328-6280 (fax) 1-800-472-2180 (toll free) https://www.ndhealth.gov/hiv/RyanWhite/

Ohio	
SHIP Name and Contact Information	Ohio Senior Health Insurance Information Program (OSHIIP) 50 W Town Street Suite 300 Columbus, OH 43215 1-800-686-1578 (toll free) 1-614-644-3745 (TTY) 1-614-644-2658 (local) http://www.insurance.ohio.gov
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Ohio Medicaid 50 West Town Street Suite 400 Columbus, OH 43215- 4197 1-800-324-8680 (toll free) 614-280-0977 (fax) 711 (TTY) http://medicaid.ohio.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Ohio HIV Drug Assistance Program (OHDAP) Ohio AIDS Drug Assistance Program (ADAP), HIV Client Services, Ohio Department of Health 246 N. High Street Columbus, OH 43215 1-800-777-4775 1-614-995-0775 https://odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/

Oklahoma	
SHIP Name and Contact Information	Oklahoma Medicare Assistance Program (MAP) 400 NE 50th Street Oklahoma City, OK 73105 1-800-763-2828 (toll free) (in state only) 1-405-521-2828 (local) (out of state only) 1-405-521-6635 (Fax) https://www.oid.ok.gov/consumers/information-for-seniors/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	SoonerCare (Medicaid) 4345 N. Lincoln Blvd. Oklahoma City, OK 73105- 5101 1-800-987-7767 (toll free) 1-405-522-7300 (local) 1-405-522-7100 (fax) 711 (TTY) https://www.oklahoma.gov/ohca.html
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Oklahoma AIDS Drug Assistance Program HIV/STD Services Division Oklahoma State Department of Health 1000 N.E. Tenth St Mail Drop 0308 Oklahoma City, OK 73117-1299 1-405-271-4636 https://oklahoma.gov/health.html

Oregon	
SHIP Name and Contact Information	Senior Health Insurance Benefits Assistance (SHIBA) P.O. Box 14480 Salem, OR 97309 1-800-722-4134 (toll free) 1-503-947-7979 (local) https://shiba.oregon.gov/Pages/index.aspx

Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Oregon Health Authority 500 Summer Street NE, E-15 Salem, OR 97301 1-800-375-2863 (toll free) 1-503-947-2340 (local) 1-503-947-5461 (fax) 1-503-945-6214 (TTY) http://www.oregon.gov/oha
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	CAREAssist Program 800 NE Oregon Street, Suite 1105 Portland, OR 97232 1-971-673-0144 1-971-673-0177 (fax) https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx

Pennsylvania	
SHIP Name and Contact Information	APPRISE 555 Walnut Street 5th Floor Harrisburg, PA 17101- 1919 1-800-783-7067 (toll free) 1-717-783-1550 (local) https://www.aging.pa.gov/Pages/default.aspx
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/

State Medicaid Office	Pennsylvania Department of Human Services (Medicaid) Forum Place 6th Floor P.O. Box 8025 Harrisburg, PA 17105-8025 1-800-692-7462 (toll free) 1-800-451-5886 (TDD) www.dhs.pa.gov
State Pharmacy Assistance Programs	Pharmaceutical Assistance Contract for the Elderly (PACE) PACE/Pacenet Program P.O. Box 8806 Harrisburg, PA 17105- 8806 1-800-225-7223 (toll free) 1-717-651-3600 (local) 1-888-656-0372 (fax) https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
AIDS Drug Assistance Program	Pennsylvania AIDS Drug Assistance Program (ADAP) Pennsylvania Department of Health Special Pharmaceutical Benefits Program 625 Forster Street H&W Bldg, Rm 611 Harrisburg, PA 17120 1-800-922-9384 1-888-656-0372 (fax) https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx

Rhode Island	
SHIP Name and Contact Information	Senior Health Insurance Program (SHIP) Office of Healthy Aging 25 Howard Ave, Building 57 Cranston, RI 02920 1-888-884-8721 (local) 1-401-462-0740 (TTY) 1-401-462-3000 https://oha.ri.gov/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/

State Medicaid Office	Executive Office of Health and Human Services Louis Pasteur Building 57 Howard Avenue Cranston, RI 02920 1-855-697-4347 (toll free) 1-401-462-5274 (local) 1-800-745-5555 (TTY) 1-401-462-3677 (fax) http://www.ohhs.ri.gov/contact/
State Pharmacy Assistance Programs	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE) Attn: RIPAE, Rhode Island Department of Elderly Affairs 74 West Road 2nd Floor, Hazard Building Cranston, RI 02920 1-401-462-0530 (local) 1-401-462-0740 (TTY) https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance
AIDS Drug Assistance Program	Ryan White HIV/AIDS Program Executive Office of Health & Human Services Virks Building, 3 West Road Suite 227 Cranston, RI 02920 1-401-462-3295 1-401-462-3677 (fax) https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx

South Carolina	
SHIP Name and Contact Information	(I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais Street Suite 350 Columbia, SC 29201 1-800-868-9095 (toll free) 1-803-734-9900 (local) 1-803-734-9886 (fax) https://aging.sc.gov/

Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	South Carolina Department of Health and Human Services (Medicaid) P.O. Box 8206 Columbia, SC 29202-8206 1-888-549-0820 (toll free) 1-803-898-2500 (local) 1-888-842-3620 (TTY) http://www.scdhhs.gov
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	South Carolina AIDS Drug Assistance Program (ADAP) DHEC Constituent Services 2600 Bull Street Columbia, SC 29211 1-800-856-9954 (toll free) https://scdhec.gov/aids-drug-assistance-program

South Dakota	
SHIP Name and Contact Information	Senior Health Information and Insurance Education (SHIINE) 2500 W. 46th St. Suite 101 Sioux Falls, SD 57105 1-800-536-8197 (toll free) http://www.shiine.net
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/

State Medicaid Office	South Dakota Medical Assistance Program (Medicaid) 700 Governors Drive Richard F. Kneip Bldg Pierre, SD 57501-2291 1-800-597-1603 (toll free) 1-605-773-3165 (local) http://dss.sd.gov/
State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	South Dakota AIDS Drug Assistance Program (ADAP) South Dakota Department of Health, Ryan White Part B CARE Program 615 E. 4th St. Pierre, SD 57501 1-800-592-1861 1-605-773-3737 https://doh.sd.gov/

Tennessee	
SHIP Name and Contact Information	Tennessee Commission on Aging & Disability -TN SHIP 502 Deaderick Street 9th Floor Nashville, TN 37243-0860 1-877-801-0044 (toll free) 1-800 848-0299 (toll free TDD) https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	TennCare (Medicaid) 310 Great Circle Road Nashville, TN 37243 1-800-342-3145 (toll free) 1-877-779-3103 (TTY) 1-855-259-0701 (Spanish) 1-615-532-7322 (fax) http://www.tn.gov/tenncare/

State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Ryan White Part B Program TN Department of Health, HIV/STD Program, Ryan White Part B Services 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower Nashville, TN 37243 1-615-741-7500 1-800-525-2437 https://www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html

Texas	
SHIP Name and Contact Information	Texas Department of Aging and Disability Services (HICAP) 1100 West 49th Street Austin, TX 78756 1-800-252-9240 (toll free) 1-512-438-3538 (fax) https://hhs.texas.gov/services/health/medicare
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Texas Health and Human Services Commission (HHSC) Medicaid Program 4601 West Guadalupe Street Austin, TX 78751 1-800-252-8263 (toll free) 1-512-424-6500 (local) 1-512-424-6597 (TTY) https://www.hhs.texas.gov/services/health/medicaid-chip

State Pharmacy Assistance Programs	Texas Kidney Health Care Program (KHC) Department of State Health Services, MC 1938 P.O. Box 149030 Austin, TX 78714-9947 1-800-222-3986 (toll free) 1-512-776-7150 (local) https://www.hhs.texas.gov/services/health/kidney-health-care
AIDS Drug Assistance Program	Texas HIV Medication Program (THMP) Texas HIV Medication Program, ATTN: MSJA, MC 1873 P.O. Box 149347 Austin, TX 78714 1-800-255-1090 1-512-533-3178 (fax) (eligibility) 1-737-255-4300 https://www.dshs.texas.gov/hivstd/meds/

Utah	
SHIP Name and Contact Information	Senior Health Insurance Information Program (SHIP) 288 North 1460 West Salt Lake City, UT 84116 1-800-541-7735 (toll free) 1-801-538-3910 (local) 1-801-538-4395 (fax) https://daas.utah.gov/seniors/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Utah Department of Health Medicaid Multi-Agency State Office Building 195 North 1950 West Salt Lake City, UT 84116 1-800-662-9651 (toll free) 1-801-538-6155 (local) 1-800-346-4128 (TTY) 1-866-608-9422 (Spanish) https://medicaid.utah.gov/

State Pharmacy Assistance Programs	Not Applicable
AIDS Drug Assistance Program	Ryan White HIV/AIDS Program Utah Department of Health, Bureau of Epidemiology 288 North 1460 West Box 142104 Salt Lake City, UT 84116-2104 1-801-538-6191 1-801-538-9913 (fax) https://epi.utah.gov/

Vermont	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) 27 Main Street Suite 14 Montpelier, VT 05602 1-800-642-5119 (toll free) 1-802-225-6210 (local) http://www.vermont4a.org/
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-319-8452 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Agency of Human Services of Vermont Center Building 280 State Drive Waterbury, VT 05671 1-800-250-8427 (toll free) 1-802-241-0440 (local) 1-802-879-5962 (fax) http://humanservices.vermont.gov/
State Pharmacy Assistance Programs	Vpharm Green Mountain Care Application and Document Processing Center 280 State Drive, NOB 1 South Waterbury, VT 05671-1500 1-800-250-8427 (toll free) https://dvha.vermont.gov/members/prescription-assistance

AIDS Drug Assistance Program	Health Resources and Services Administration (HRSA) Vermont Department of Health, Vermont Medication Assistance Program 108 Cherry Street- P.O. BOX 70 Burlington, VT 05402 1-800-464-4343 1-802-863-7200 https://www.healthvermont.gov/immunizations-infectious-disease/hiv/care

Virginia	
SHIP Name and Contact Information	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Avenue Suite 100 Henrico, VA 23229 1-800-552-3402 (toll free) 1-804-662-9333 (local) 1-804-552-3402 (toll free TTY) http://www.vda.virginia.gov
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Department of Medical Assistance Services (Medicaid) 600 East Broad Street Suite 1300 Richmond, VA 23219 1-855-242-8282 (toll free) 1-804-786-7933 (local) 1-888-221-1590 (TTY) https://www.dmas.virginia.gov/for-members/
State Pharmacy Assistance Programs	Virginia State Pharmaceutical Assistance Program HCS Unit, 1st Floor James Madison Building 109 Governor Street Richmond, VA 23219 1-855-362-0658 (toll free) 1-804-864-8050 (fax) https://www.vdh.virginia.gov/disease-prevention/vamap/

AIDS Drug Assistance Program	VIRGINIA MEDICATION ASSISTANCE PROGRAM (VA MAP) Virginia Department of Health, HCS Unit 1st Floor, James Madison Building 109 Governor Street Richmond, VA 23219 1-855-362-0658 1-804-864-8050 https://www.vdh.virginia.gov/disease-prevention/vamap/

Washington	
SHIP Name and Contact Information	Statewide Health Insurance Benefits Advisors (SHIBA) Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 1-800-562-6900 (toll free) 1-360-586-0241 (TTY) http://www.insurance.wa.gov/shiba
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-305-6759 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Apple Health (Medicaid) Cherry Street Plaza 626 8th Avenue SE P.O. Box 45531 Olympia, WA 98501 1-800-562-3022 (toll free) 711 (TTY) http://www.hca.wa.gov/
State Pharmacy Assistance Programs	Not Applicable

AIDS Drug Assistance Program	Washington State AIDS Drug Assistance Program (ADAP)Early Intervention Program (EIP) Client Services P.O. Box 47841 Olympia, WA 98504 1-877-376-9316 (in Washington state) 1-360-664-2216 (fax) 1-360-236-3426 http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP

West Virginia	
SHIP Name and Contact Information	West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East Charleston, WV 25305 1-877-987-4463 (toll free) 1-304-558-3317 (local) 1-304-558-0004 (fax) www.wvship.org
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax https://livantaqio.com/
State Medicaid Office	West Virginia Department of Health and Human Resources (Medicaid) 350 Capitol Street Room 251 Charleston, WV 25301-3709 1-800-642-8589 (toll free) 1-304-558-1700 (local) 1-855-889-4325 (TTY) http://www.dhhr.wv.gov/bms
State Pharmacy Assistance Programs	Not Applicable

AIDS Drug Assistance Program	West Virginia AIDS Drug Assistance Program (ADAP) Jay Adams, HIV Care Coordinator P.O. BOX 6360 Wheeling, WV 26003 1-304-232-6822 http://oeps.wv.gov/rwp/pages/default.aspx

Wisconsin	
SHIP Name and Contact Information	WI State Health Ins. Assist. Program (SHIP) 1 West Wilson Street Madison, WI 53703 1-800-242-1060 (toll free) 711 or 1-800-947-3529 (TTY) 1-608-266-1865 (local) www.dhs.wisconsin.gov/benefit-specialists/ship.htm
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax https://livantaqio.com/
State Medicaid Office	Wisconsin Department of Health Services (Medicaid) 1 West Wilson Street Madison, WI 53703-3445 1-800-362-3002 (toll free) 1-608-266-1865 (local) 1-800-947-3529 (TTY) http://www.dhs.wisconsin.gov
State Pharmacy Assistance Programs	Wisconsin SeniorCare P.O. Box 6710 Madison, WI 53716- 0710 1-800-657-2038 (toll free) http://www.dhs.wisconsin.gov/seniorcare/

AIDS Drug Assistance Program	Wisconsin AIDS/HIV Drug Assistance and Insurance Assistance Programs Division of Public Health, Attn: ADAP P.O. Box 2659 Madison, WI 53701 1-800-991-5532 1-608-266-1288 (fax) 1-608-267-6875 https://www.dhs.wisconsin.gov/hiv/adap.htm

Wyoming	
SHIP Name and Contact Information	Wyoming State Health Insurance Information Program (WSHIIP) 106 West Adams Riverton, WY 82501 1-800-856-4398 (toll free) 1-307-856-6880 (local) 1-307-856-4466 (Fax) www.wyomingseniors.com
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 1-888-317-0891 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Wyoming Department of Health, Division of Healthcare Financing (Medicaid) 122 West 25th St 4th Floor West Cheyenne, WY 82001 1-866-571-0944 (toll free) 1-307-777-7656 (local) 1-307-777-6964 (fax) https://health.wyo.gov/healthcarefin/medicaid/
State Pharmacy Assistance Programs	Not Applicable

AIDS Drug Assistance Program	Wyoming Aids Drug Assistance Program (ADAP) Wyoming Department of Health 401 Hathaway Building Cheyenne, WY 82002 1-307-777-7529 (Debi Anderson, CDU Unit Manager) 1-307-777-5279 (fax) https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/

LINET
LIMITED INCOME NET PROGRAM

Method	Customer Care – Contact Information
CALL	1-800-783-1307 Calls to this number are free. [Monday through Friday 8 a.m. to 7 p.m., Eastern time.] Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are listed above.
FAX	1-877-210-5592
WRITE	Limited Income NET Program P.O. Box 14310 Lexington, KY 40512-4310
WEBSITE	Humana.com/LINET

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Contact information for your SHIP can be found in "Exhibit A" in this document.

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